

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-036325

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8720

FILED SEP 17 1962

VS 300
Rev. 4/59

1

40162

3

4 /

5 /

6

7 /

8 2

9

10

11

12 52-0

13

52

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis		c. CITY OR TOWN Bel-Ridge		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BAKES HOSPITAL				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 9050 Natural Bridge				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Phyllis L. Johnson						4. DATE OF DEATH Month Day Year September 8, 1962					
5. SEX Female		6. COLOR OR RACE White		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 4/15/36		9. AGE (last birthday) 26		IF UNDER 1 YEAR Months Days 26	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Recep				10b. KIND OF BUSINESS OR INDUSTRY Advert		11. BIRTHPLACE (City and state or country) Colorado			12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME Wesley F. Morton				13b. MOTHER'S MAIDEN NAME Gladys Shaklee				14. NAME OF HUSBAND OR WIFE Stanley Johnson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No						16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mr. Stanley Johnson 9050 Natural Bridge			
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year											
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE			
21. I attended the deceased from <u>9/3/62</u> to <u>9/8/62</u> and last saw her/him alive on <u>9/8/62</u> Death occurred at <u>3:30</u> P.m. on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE <i>James Pennoyer</i> M.D.						22b. ADDRESS BARNES HOSPITAL				22c. DATE SIGNED 9/9/62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 9/12/62		23c. NAME OF CEMETERY OR CREMATORY Cypress Lawn Cemetery				23d. LOCATION (City, town, or county) Everett, Washington			
24. FUNERAL DIRECTOR Calvin F. Feutz 4828 Natural Bridge Blvd.						25. DATE RECD. BY LOCAL REG. 9-10-62		26. REGISTRAR'S SIGNATURE <i>Earl Smith</i> M.D.			

USE BLACK INK
OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Robert E. Muhlman

Licensed Embalmer No. 4916

P. O. Address St. Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.